PS6190.02 INFECTIOUS DISEASE MANAGEMENT

Change

Notice

DIRECTIVE BEING CHANGED:
6190.02
CHANGE NOTICE NUMBER: CN-01
DATE:
February 12, 1997

1. PURPOSE AND SCOPE. To revise PS 6190.02, Infectious Disease Management as it pertains to TB screening.

2. SUMMARY OF CHANGES. This Change Notice mandates TB testing for all inmates and incorporates procedures to ensure compliance.

3. TABLE OF CHANGES

Remove	Insert
Pages 7 and 8	Pages 7 and 8 (CN-01)
Pages 21 and 22	Pages 21 and 22 (CN-01)

4. ACTION. File this Change Notice in front of PS 6190.02, Infectious Disease Management.

Kathleen M. Hawk
Director

Program

Statement

OPI: HSD
NUMBER: 6190.02
DATE: October 3, 1995
SUBJECT: Infectious Disease Management

RULES EFFECTIVE DATE: October 5, 1995

1. **[PURPOSE AND SCOPE § 549.10. This policy is designed to provide instruction and guidance in the management of infectious diseases in the confined environment of a correctional setting.]**

Contagious disease processes in the confined environment of a prison can have a devastating impact and severely stress local financial and human resources. Chronic disease processes or conditions, such as hepatitis and HIV infection, can progress to catastrophic results for the individual patient and pose difficult management problems and priorities.

2. PROGRAM OBJECTIVES. The expected results of this program are:

a. The incidence, prevalence, and attenuating health risks of infectious diseases will be reduced.

b. Staff and inmates will receive appropriate training, education, and counseling on disease prevention.

c. Risks of infection will be reduced by universal precautions, engineering and work practice controls, and use of personal protection equipment.

c. Written, informed consent will be obtained before drawing any blood or other specimin, as required in this Program Statement, for example, to determine if exposure to an infectious disease has occurred.

d. Infectious waste will be stored, handled, and disposed of in accord with with OSHA standards.

e. Medical information about employees and inmates will be regarded as confidential and released only to persons and agencies specified in this Program Statement and in accordance with the standards and requirements of the Centers for Disease Control and Prevention, the Freedom of Information Act, and the Privacy Act.

[Bracketed Bold - Rules]
Regular Type - Implementing Information

f. Mandatory HIV testing programs will be conducted annually.

g. All HIV and HBV antibody testing will be accompanied by pre- and post-test counseling.

h. The standards on Bloodborne Pathogens of the Occupational Safety and Health Administration will be met.

3. DIRECTIVES AFFECTED

a. Directives Rescinded

P.S. 6190.01	Human Immunodeficiency Virus (HIV) Programs (01/22/91)
O.M. 029-95	Bloodborne Pathogens (02/24/95)

b. Directives Referenced

P.S. 1351.02	Privacy Act of 1974 (09/25/75)
P.S. 1353.01	Information, Release of Records (05/29/75)
P.S. 1600.06	Occupational Safety and Environmental Health Manual (02/25/92)
P.S. 5050.44	Compassionate Release, Procedures for Implementation of 18 U.S.C. 3582(c)(1)(A) and 4205(g) (01/07/94)
P.S. 5214.03	Procedures for Handling HIV Positive Inmates Who Pose a Danger to Others (10/02/87)
P.S. 5500.06	Guard Service at Local Medical Facilities (12/15/93)
P.S. 6000.04	Health Services Manual (12/15/94)

c. Rules cited in this Program Statement are contained in 28 CFR §§ 549.10 through 549.18.

d. Rules referenced in this Program Statement are contained in 5 CFR § 339.102 and § 339.301 through § 339.305 and 29 CFR § 1910.1030 (Bloodborne Pathogens).

4. STANDARDS REFERENCED

a. American Correctional Foundation/Core Standards for Adult Correctional Institutions: C2-4136, C2-4173.

b. American Correctional Association 3rd Edition Standards for Adult Correctional Institutions: 3-4268, 3-4365, 3-4366.

c. American Correctional Foundation/Core Standards for Adult Local Detention Facilities: FC2-5092, C2-5175.

d. American Correctional Association 3rd Edition Standards for Adult Local Detention Facilities: 3-ALDF-3E-08, 4E-25, 4E-36.

e. American Correctional Association 2nd Edition Standards for the Administration of Correctional Agencies: 2-CO-4E-01.

5. HEALTH PROMOTION. Disease prevention programs have been used to effectively limit the impact of both communicable diseases and chronic medical conditions. Diseases and conditions detected in early or initial stages often may be cured or the disease process arrested. Effective health promotion/disease prevention programs emphasize the individual as a cooperative participant in the health care process rather than a passive recipient. The health promotion concept encompasses:

a. Disease Prevention, which seeks to intervene in the course of the development or pathogenesis of a disease.

(1) Primary Prevention (Pre-pathogenic period), which seeks to identify harmful habits or lack of knowledge in an otherwise healthy person and counsel him/her to prevent disease.

(2) Secondary Prevention (Clinical appearance of disease with aim at restoring pre-disease state of health), which seeks to identify disease in the pre-clinical stage and intervene to prevent progression.

(3) Tertiary Prevention (Chronic disease with aim of optimizing the quality of health and minimizing complications and preventing further progression), which seeks to identify disease after it is clinically apparent and intervene to prevent further deterioration.

b. Health Protection, which is a set of activities which are undertaken to manipulate the environment to protect a person's health.

c. Health Education, which is any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

d. Environmental Controls, which are controls or processes (e.g., negative pressure rooms, ventilation systems, microbial filtration devices, etc.) that isolate or remove pathogens from the work and/or living environment.

e. Engineering Controls, which are measures or controls (e.g., containers for disposal of sharp items, self-sheathing needles, etc.) that isolate or remove a pathogen from the work and or living environment.

f. Personal Protective Equipment, which is specialized clothing or equipment worn by an individual for protection against pathogens or infected material. General work clothes (e.g., uniforms, pants, shirts, blouses, etc.) which are not intended to function as protection against a hazard are not considered to be personal protective equipment.

6. GENERAL MANAGEMENT. The Health Services Administrator (HSA) and Clinical Director (CD) of each institution shall develop procedures to identify and assess infectious diseases and related health risks and implement practices and procedures which reduce disease incidence, prevalence, and attenuating health risks.

All practices shall conform to current standards of medical practice and comply with established and published guidelines and recommendations from:

- # the Centers for Disease Control and Prevention (CDC),
- # the CDC's Advisory Committee for Immunization Practices (ACIP),
- # the Occupational Safety and Health Administration (OSHA),
- # the National Institutes for Occupational and Health (NIOSH), and
- # the Department of Health and Human Services (DHHS).

When specific practices or procedures allow for modification of these national guidelines and regulations, the Medical Director shall issue Operations Memoranda defining the specific implementation.

The Medical Director shall issue implementing Operations Memoranda for all guidelines, standards, and regulatory policy pertaining to this program, e.g., issuance of OSHA standard 1910.1030 with cover memorandum implementing the standard.

a. Disease Prevention

(1) Infectious diseases and health risks may be identified by various means, e.g., health screenings, risk assessments, physical examinations, laboratory reports, patient histories, injury reports, review of food preparation and serving, and professional literature.

Identification and assessment mechanisms shall be evaluated and implemented through the institutional Quality Improvement Program.

(2) The HSA and CD of each institution shall establish health promotion policies and practices which encompass disease prevention, health protection, and health education for infectious diseases.

(3) Practices shall be implemented which minimize the complications of diseases, and either restore the pre-disease state of health, or prevent progression of the disease.

Such practices and procedures are to allow for the identification of risks in the primary, secondary, and tertiary disease stages.

b. Health Protection. Practices and procedures shall be implemented which identify and reduce environmental health risks.

These practices and procedures shall comply with Federal regulations, OSHA standards, and the current recommendations and guidelines of the Department of Health and Human Services (DHHS) and its agencies.

c. Health Education. Patient education practices and procedures shall be developed and implemented in order that employees and inmates may make informed decisions and judgments, and actively participate in their health care.

7. **[PROGRAM RESPONSIBILITY § 549.11]**. The Medical Director shall disseminate to all HSAs program information as it becomes available from health care agencies. The Program Review Division, Health Services section, shall assess each institution's compliance with this Program Statement. The National Infectious Disease Program Coordinator shall develop specific assessment criteria for the Program Review Division's use to evaluate the performance of institutional programs. The criteria shall be specific, measurable, attainable, and relevant to this program.

The Health Services Division shall educate and guide institution health services units in current procedures and treatments as they are developed and approved for use.

[a. The HSA and CD of each institution shall be responsible for the development and implementation of this program.]

The HSA shall be responsible for monitoring the effectiveness of the overall program, including policies, practices, and procedures.

[b. Each HSA shall designate a member of the clinical health care staff, for example, physician, dentist, physician assistant, nurse practitioner, or nurse as the Coordinator of Infectious Diseases (CID).]

The CID shall be responsible for employee and inmate education, compilation of data, construction of epidemiology and surveillance reports, and the integrity of the reporting mechanisms, including the SENTRY Sensitive Medical Data (SMD) reporting system. The CID shall prepare reports and summaries of disease prevalence and incidence and make these available to the institutional quality assurance committee.

The CID shall receive Continuing Professional Education on infectious diseases each year. All education shall meet the certification requirements of a medical professional accrediting body or organization which certifies health professionals nationally, e.g., the American Medical Association, American Nursing Association, National Commission for the Certification of Physician Assistants, American Dental Association.

8. MONITORING, **[REPORTING]**, AND SURVEILLANCE **[§ 549.12. The HSA shall ensure that each institution's respective state health department is informed of all cases of reportable infectious diseases.]**

All reportable infectious diseases are identified on the SMD Outpatient Morbidity Classification Reporting Form (BP-S504.063). Each institutional CID shall ensure that all cases of infectious diseases are entered into the SENTRY SMD system consistent with current policy. Patient evaluation and follow-up shall be consistent with the most current CDC recommendations.

Reporting criteria and procedures differ among states; therefore, the HSA or CD should establish and maintain frequent communication with the state health department.

The CID shall monitor prevalence and incidence information through retrieval of information from the SENTRY SMD system and/or the Key Indicator Strategic Support System (KI/SSS). The CD shall ensure that incidence and prevalence data is available and appropriately documented and reported. Incidence and prevalence information shall be an established indicator for the quality assurance committee's review of the institution's health services unit.

[See § 549.17 for reporting requirements of chronic infectious diseases and for Freedom of Information Act requests.]

28 CFR § 549.17 refers to Section 16 of this Program Statement.

9. TREATMENT AND PRACTICE GUIDELINES. All institutions shall subscribe to the CDC's **Morbidity and Mortality Weekly Report**. Specific guidelines and recommendations for identification, prevention, and treatment are contained in this publication. The HSA shall maintain copies of this publication in the medical library for medical staff access as needed or requested. The HSA shall maintain documentation that the HSA and CD have reviewed each edition of the **Morbidity and Mortality Weekly Report**.

10. **[MEDICAL TESTING § 549.13**

a. Bloodborne pathogens. Following an incident in which a staff member or an inmate may have been exposed to bloodborne pathogens, written, informed consent shall be obtained prior to acquiring or processing the source individual's blood or other biological specimen for the purpose of determining an exposure to a bloodborne pathogen. In the context of exposure incidents, no inmate shall be tested forcibly or involuntarily, unless such testing is ordered by a court with proper jurisdiction. Inmates may be subjected to disciplinary action for assaultive behavior related to an exposure incident.

b. <u>HIV testing</u>. HIV testing programs are mandatory and include a yearly random sample, yearly new commitment sample, new commitment re-test sample, pre-release testing, and clinically indicated testing. Inmates must participate in all mandatory testing programs. Staff shall initiate an incident report for failure to follow an order for any inmate refusing one of the mandatory HIV testing programs.

c. <u>Diagnostics</u>. (1) An inmate who refuses routine diagnostic procedures and evaluations for infectious and communicable diseases shall be subject to an incident report for failure to follow an order; involuntary testing subsequently may be performed in accordance with paragraph (c)(3) of this section.

(2) Any inmate who refuses clinically indicated diagnostic procedures and evaluations for infectious and communicable diseases shall be subject to isolation or quarantine from the general population until such time as he/she is assessed to be non-communicable or the attending physician determines the inmate poses no health threat if returned to the general population.]

If inmates must be isolated from the general population, the CD shall ensure that environmental/engineering controls, personal protective equipment, and other infection control measures are adequate to prevent or contain the transmission of the disease. The CD shall administer all tests, evaluations, and procedures necessary to diagnose the specific disease consistent with the current guidelines of the Department of Health and Human Services (DHHS).

[(3) If isolation is not practicable, an inmate who refuses to comply with or adhere to the diagnostic process or evaluation shall be involuntarily evaluated or tested.]

The CD may delegate the administration of screening tests to other qualified health care providers.

* TB screening is mandatory for all inmates. All newly committed inmates shall receive TB screening by PPD (mantoux method) or chest x-ray. The PPD shall be the primary screening method unless this diagnostic test is contraindicated; then a chest x-ray shall be obtained.

If an inmate refuses both the PPD test and a chest x-ray, then, the institution shall involuntarily test the inmate. For tracking purposes, after involuntary testing for TB, the CD shall send a report to the Bureau Medical Director with a copy to the respective Regional Director. The report must contain:

- the inmate's name and register number,
- the specific disease for diagnosis, and

P some indication that education and counseling have been provided to the inmate in a format appropriate in content and vocabulary to the inmate's educational level, literacy, and language. *

The CD shall educate and counsel any inmate prior to the involuntary use of any procedure. The CD shall fully and carefully explain the necessity and details of any and all required procedures or evaluations. If the counseling and education techniques are not successful, the diagnostic procedure or evaluation shall be administered. Staff shall only use the amount of force necessary to gain the inmate's compliance. The CD shall document the education and counseling as well as the specific diagnostic evaluation or procedure in the inmate's medical record.

11. **[TRAINING § 549.14. The HSA shall ensure that a qualified health care professional provides training, incorporating a question-and-answer session, about infectious diseases to all newly committed inmates, during Admission and Orientation (A&O). Additional training shall be provided at least yearly.]**

Training for recently hired employees shall be given during Institutional Familiarization (I&F).

a. Content. This training shall cover identification, screening, methods of transmission, treatment, and prevention of infectious diseases. The inmates trained annually shall be those inmates identified in the institution's Infectious Disease Control Plan as being at risk.

b. Adaptation for Specific Needs. All training and education shall be provided in a format appropriate in content and vocabulary to the educational level, literacy, and language of the employees and inmates.

c. Publications. The DHHS publications shall be used as the primary source of educational and training materials (e.g., **A Curriculum Guide For Public-Safety and Emergency-Response Workers**, (DHHS) and (NIOSH), publication number 89-108, and **Core Curriculum on Tuberculosis**, (CDC) publication, U.S. Government Printing Office: 1992-733-974).

12. EMPLOYEE HEALTH CARE. Employees shall receive only urgent or emergent care which must be rendered immediately to provide for the general health. All health care not specifically covered under the Health Service Manual and attending Program Statements, shall be referred to the employee's private health care provider. Only those tests, evaluations, immunizations, and/or vaccinations specifically covered in the Bureau of Prisons health service policy shall be provided to employees.

a. Clinical Director Evaluation. The CD or attending physician shall evaluate or assess any employee believed to have an infectious disease. Employees shall be referred to their private health care provider for treatment. The CD shall require documentation from the employee's health care provider of any treatments and recommendations for care or employment. The employee must provide written consent, which shall be maintained in the employee's medical record, for the release of information allowing the transfer of the information to the CD.

b. Clinical Director's Recommendation. The CD shall make recommendations to the Warden regarding duty assignment or employment status consistent with 5 CFR §339.101-339.306. The recommendations shall be consistent with the employee's health status and any potential risks of transmitting an infectious disease or threat to the health and well-being of other inmates or employees.

All recommendations from the CD regarding an employee's duty assignment shall be made in writing to the Warden. The recommendations shall be made in collaboration with the institution Human Resource Manager and be consistent with current Office of Personnel Management regulations and 5 CFR §339 (all subparts).

c. Duty Modification. In cases involving an employee under evaluation for an infectious disease, the institution CD shall make any recommendations to the Warden regarding any modification of duties required to ensure the individual's health and preventing transmission of the disease to others.

13. **[MEDICAL ISOLATION AND QUARANTINING § 549.15**

a. The CD, in consultation with the HSA, shall ensure that inmates with infectious diseases which are transmitted through casual contact (e.g., tuberculosis, chicken pox, measles) are isolated from the general inmate population until such time as they are assessed or evaluated by a health care provider.

b. Inmates shall remain in medical isolation unless their activities, housing, and/or duty assignments can be limited or environmental/engineering controls or personal protective equipment is available to eliminate the risk of transmitting the disease.]

14. **[DUTY AND HOUSING RESTRICTIONS § 549.16**

a. The CD shall assess any inmate with an infectious disease for appropriateness for duties and housing. Inmates demonstrating infectious diseases, which are transmitted through casual contact, shall be prohibited from employment in any area, until fully evaluated by a health care provider.

b. Inmates may be limited in duty and housing assignments only if their disease could be transmitted despite the use of environmental/engineering controls or personal protective equipment, or when precautionary measures cannot be implemented or are not available to prevent the transmission of the specific disease. The Warden, in consultation with the CD, may exclude inmates, on a case-by-case basis, from work assignments based upon the classification of the institution and the safe order of the institution.

c. With the exception of the Bureau of Prisons rule set forth in subpart E of 28 CFR part 541, there shall be no special housing established for HIV-positive inmates.]

Subpart E of 28 CFR 541 refers to rules contained in the Program Statement on Procedures for Handling HIV Positive Inmates Who Pose a Danger to Others.

15. INFECTIOUS WASTE. Infectious waste shall meet the specifications set forth in the OSHA standard found in 29 CFR, §1910.1030. All infectious waste shall be handled and disposed of in accordance with 29 CFR, §1910.1030.

a. Infectious Waste Procedures and Policies. These guidelines are developed to ensure the safe management and disposal of hospital waste generated at Bureau health services units and medical centers. The objective of these guidelines is to achieve a free-flowing path for the movement of waste from generation to disposal, minimize risk to personnel, and maintain aesthetic values by keeping waste out of sight of inmates and visitors.

b. Definitions

(1) Infectious Waste. Contains pathogenic agents that, because of their type, concentration, and quantity, may cause disease in persons exposed to such waste.

(2) Municipal Solid Waste (MSW). Contains general trash and garbage. Included are food waste from kitchens and anything, other than infectious waste, discarded in nonmedical areas.

(3) Storage Areas. Are used for storage of infectious waste before disposal.

(4) Contaminated Laboratory Waste. Refers to waste that has been in contact with pathogens in any type of laboratory work including, but not limited to, culture dishes, pipettes, syringes and other "sharps," tissue culture bottles and flasks, membrane filters in plastic dishes, collect bottles, cups and tubes from specimens, micro-titer plates, slides, plates, cover slips, disposable gloves, lab coats and aprons, swabs, capillary tubes and spreaders, centrifuge tubes, and Hepa filters from laminar hoods, etc.

c. On-site Treatment

(1) Sterilization of waste in an autoclave.

(2) Incineration in a multi-chambered state approved incinerator.

(3) Decontamination of infectious waste by other technologies in a manner acceptable to the local department of health.

(4) Bulk blood, suction fluids, excretions, and secretions may be carefully poured down a drain connected to a sanitary sewer.

d. Storage Area

(1) Store the infectious waste in a manner and location that maintains the integrity of the packaging and provides protection from outside elements, rodents, and vermin.

(2) Maintain the infectious waste in a non-putrescent state, using refrigeration/air conditioning when necessary.

(3) Avoid congested and visitor areas.

(4) Lock and post with the biological hazard symbol.

(5) Provide an exhaust system to the outside and provide a smooth, impervious floor.

e. Responsibilities

(1) Each floor/ward supervisor shall devise an effective waste management and waste handling plan for their respective floor/ward. These plans shall be forwarded to the Safety Manager and HSA for review.

(2) HSAs shall provide a written endorsement of the waste management and waste handling plans.

(3) HSAs and Safety Managers have joint responsibility for policies and procedures needed to develop the waste management plan. The HSA is responsible for implementing and complying with the policies and procedures established for medical centers and health services units. The Safety Manager is responsible for monitoring surveys as outlined in the Occupational Safety and Environmental Health Manual and providing technical consultation.

(4) All medical personnel (physicians, dentists, nursing services staff, laboratory staff, health technicians, etc.) who generate waste, as defined in this instruction, as a result of patient diagnosis, treatment, or therapy, must ensure reasonable

protection to patients, staff, visitors, and the community. This responsibility will be met by adhering to the policies and procedures delineated in this Program Statement and the most current Bureau policy on the OSHA Standard on "Bloodborne Pathogens."

(5) Hospital hazardous waste will be handled in accordance with the most current Operations Memorandum on Hazardous Waste Management.

f. Type of Infectious Waste

(1) Blood and Blood Products. Blood products and their containers to include: blood tubes, vials, transfusion bags and tubing, suction/drainage bags, dressing, bandages, and 2x2's that are soiled with blood and/or body fluids.

(2) Pathological Waste. Consists of human tissues, organs, body parts, and blood and body fluids that are removed during emergency surgical procedures.

(3) Other Waste. Other wastes from emergency surgical procedures include soiled dressings, sponges, drapes, underpads, surgical gloves, etc., that come in contact with patient tissues, blood, body fluids, secretions, and excretions.

(4) Sharps. Present the double hazard of inducing disease and inflicting injury. Sharps include needles, syringes, Pasteur pipettes, broken glass, scalpel blades, razor blades, etc.

(5) Discarded Biological. Live vaccines for human use.

(6) Contaminated Equipment. Disposable equipment contaminated with pathogens, e.g., suction canisters, drainage bags, and Hepa filters from biological safety cabinets.

g. Procedures

(1) All MSW shall be placed into a regular plastic bag before introduction into the waste disposal stream.

(2) Sanitary napkins shall be disposed of as follows:

(a) Women shall place a used sanitary napkin in a sealable impermeable bag of sufficient size to contain an individual napkin. These bags shall be provided for this purpose.

(b) Each impermeable bag shall be placed in a lined covered trash container provided for this purpose.

(c) Housekeeping shall remove the liner from the container, tie it shut, and dispose of it in the MSW waste stream.

(3) Each activity (patient care, clinics, treatment rooms, laboratory, etc.) shall separate infectious and hazardous waste from MSW.

(4) Red plastic bags imprinted "Infectious Waste" shall be used only for infectious waste (exceptions include needles, syringes, "sharps," liquids,). Plastic bags other than red or orange shall be used for MSW.

(5) Place infectious waste in a red plastic bag. Seal the bag with tape or tie securely (carefully remove excess air before sealing). Place in a second plastic bag (total 3.0 mil thickness) or cardboard box labeled "Infectious Waste."

(6) Sealed bags/boxes shall be transported from floor/ward directly to the storage areas and stacked in an orderly manner. Bags should not be filled excessively, nor thrown into carts or from one individual to another.

(7) Infectious waste must never be deposited in open containers. Receptacles labeled "Infectious Waste" with foot-controlled lids, lined with red plastic bags shall be used to collect infectious waste. The lid must remain in the closed position. Waste receptacles must be emptied daily and cleaned with an approved disinfectant-detergent.

(8) Immediately after use, all "sharps" (syringes, needles, razors, and other sharp items, except Dental syringes) shall be placed intact in rigid leakproof and puncture resistant containers. Disposable needles and syringes shall not be cut, broken, bent, or recapped. This procedure will prevent aerosol generation created by clipping needles. When 3/4 full, "sharp" containers shall be closed, sealed, and placed in a red plastic bag for transport and disposal. (Accountability procedures shall be according to local policies.)

(9) Immediately after use, dental needles are to be carefully recapped, removed from the reusable syringe, and placed in rigid leakproof and puncture resistant containers.

(10) Containers used by each floor/ward for transporting infectious waste directly to the storage areas shall be labeled "Infectious Waste Only." Bulk collection of infectious waste from different floors/wards shall not be allowed.

(11) Infectious waste shall not be stored in patient rooms (with the except of isolation where entry is kept to a minimum).

(12) Laboratory waste shall be disposed of as specified in the Laboratory Procedures Manual.

(13) When handling infectious waste, all precautions shall be followed as outlined in the most recent Bureau policy transmitting the OSHA Standard on "Bloodborne Pathogens."

(14) A designated representative shall be responsible for the timely removal of used "sharps" from the clinical areas (exam rooms, wards, dental areas, etc.).

h. Housekeeping. In accordance with public health practices and to aid in vermin control, storage of infectious waste must be minimized. Containers must be kept securely closed. The containers and storage areas must be periodically scheduled for cleaning by the housekeeping staff. If a bag should break or tear during transportation, the contents should be immediately bagged. Any liquid spillage from a torn bag must be cleaned up immediately with an absorbent and bagged. The spillage area should be mopped and cleaned with an approved disinfectant.

i. Minimization and Recycling. Each health service unit and Medical Center shall follow all guidelines outlined in the the most recent Bureau policy on Environmental Awareness Pollution Prevention Program.

16. **[CONFIDENTIALITY OF INFORMATION § 549.17]**

Information related to any patient's medical condition, employee or inmate, ordinarily is regarded as confidential, with knowledge and access restricted to members of the medical staff. Any release of information shall be in accordance with the Freedom of Information Act (FOIA) and the Privacy Act of 1974. As indicated below, institution staff may also be authorized to have access when they have a legitimate need to know.

[a. Medical information relevant to chronic infectious diseases shall be limited to members of the institution medical staff, institutional psychologist, and the Warden and case manager, as needed, to address issues regarding pre- and post-release management. Prior to an inmate's release, medical information shall be shared with the United States Probation Officer in the respective area of intended release for the inmate and with the Director of the Community Correctional Center (CCC) for purposes of post-release management and access to care. Any other release of information shall be in accordance with the Privacy Act of 1974.]

When the institution physician has assessed that an exposure to an infectious agent has occurred, information relevant to the exposure incident regarding an inmate's and/or employee's medical condition may be communicated to an employee's private physician upon written request (i.e., a FOIA request) from the exposed employee's physician showing compelling circumstances affecting

the employee's health or safety and with the employee's written consent. When these criteria are met, the institution CD or attending physician shall provide the community physician with a copy of the exposure determination report. The CD or attending physician shall consult with the Regional Counsel to ensure the disclosure report conforms with the requirements of the Privacy Act. The report shall include human immunodeficiency virus (HIV), hepatitis B virus (HBV), or other pertinent infectious disease information about the source individual to the extent such information is known.

Prior to disclosing information regarding a source individual's status, the CD shall seek consent from the source individual (though the information may be disclosed even if consent is withheld) and the CD shall subsequently notify the individual of the disclosure. The exposed employee's physician shall be instructed as to the importance of maintaining strict confidentiality of all medical information regarding the source individual.

When the exposed individual is an inmate, he or she will be treated by staff from the institution's Health Services Unit. The course of treatment will be based upon a host of factors including the source individual's test results, if known. The source individual's test results shall not be disclosed to the inmate.

[b. All parties, with whom confidential medical information regarding another individual is communicated, shall not share this information, by any means, with any other person. Medical information may be communicated among medical staff directly concerned with a patient's case in the course of their professional duties.]

17. **[HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND HEPATITIS B VIRUS (HBV) § 549.18**

a. During routine intake screening, all new commitments shall be interviewed to identify those who may be HIV-or HBV-infected. Medical personnel may request any inmates identified in this manner to submit to an HIV or HBV test. Failure to comply shall result in an incident report for failure to follow an order.]

Medical staff questions should address specific symptoms such as thrush, nausea, fevers, chills, night sweats, cough, unexplained weight loss, lymphadenopathy, and diarrhea. Inmates should be questioned regarding high risk behaviors, sexual activity, intravenous drug use, or blood transfusion. Medical staff shall make the determination that testing is clinically indicated.

[b. A seropositive test result does not constitute sole grounds for disciplinary action. Disciplinary action may be considered when coupled with a secondary action that could lead to transmission of the virus, e.g. sharing razor blades.]

HIV and HBV testing is administered in conjunction with a developed education and counseling program. Appropriate emphasis must be placed on education, counseling, testing, and treatment. Testing and reporting of seropositive test results serves as a basis for the formulation of AIDS, HIV, and HBV care, treatment, and management, as well as fiscal policy.

Blood samples submitted to the contract laboratory shall be tested initially using the Enzyme-linked Immunosorbent Assay (ELISA). Positive ELISAs shall be repeated on the initial sample. If the second ELISA is positive, a confirmatory Western Blot is performed on the sample. If the Western Blot is found to be indeterminate or contradicts the ELISA result, a second sample shall be drawn in 30 days. Only a positive result, confirmed by a Western Blot, shall be entered in the medical file and keyed into the SENTRY SMD category.

The institution physician shall classify all inmates with a confirmed positive HIV or HBV antibody test using the appropriate CDC classification, following the CDC guidelines in Attachment A. Medical staff shall note the classification in the inmate medical file and enter it into the SENTRY SMD system.

Medical staff shall enter all test results into the Laboratory Reports section of the inmate medical file.

The HSA is responsible for monitoring the number of HIV and HBV antibody tests conducted as well as the test results. The HSA shall ensure that all HIV testing and results are entered into the SENTRY SMD category.

[c. From time-to-time a sample of all newly incarcerated inmates committed to the Bureau of Prisons shall be tested.]

Unless otherwise instructed by the Medical Director, this new commitment sample shall be conducted each year from November 1 through November 30. All inmates in this sample shall be entered into the SENTRY SMD classification system as both a new commitment and retest assignment.

All inmates in the new commitment group who continue to test negative shall be entered in the retest group and shall be tested every January and July thereafter. The new commitment (incarcerated) as well as the retest programs are mandatory. Failure to comply shall result in an incident report for failure to follow an order.

[d. Additionally, a random sample for HIV of all inmates in the Bureau of Prisons shall be conducted once yearly. Inmates tested in this random sample shall not be scheduled for follow-up routine retesting.]

This random test program shall be conducted from August 1 through August 31 of each year. Participation in the random testing sample is mandatory. Any refusal shall be subject to an incident report for failure to follow an order.

The Office of Research and Evaluation shall determine the random method with advance notification provided to the institutions. For accurate tracking of the samples, each inmate tested shall be entered in SENTRY under the SMD classification system. Access to this information is restricted to the institution, regional office, and Central Office health service staff.

[e. After consultation with a Bureau of Prisons' health care provider, an inmate may request an HIV/HBV antibody test. Ordinarily, an inmate will not be allowed to test, as a volunteer, more frequently than once yearly.]

All inmates tested in this manner shall be entered in the SENTRY SMD Classification System.

[f. A physician may order an HIV/HBV antibody test if an inmate has chronic illnesses or symptoms suggestive of an HIV or HBV infection. Inmates who are pregnant, inmates receiving live vaccines or inmates being admitted to community hospitals, if required by the hospital, shall be tested. Inmates demonstrating sexual behavior which is promiscuous, assaultive, or predatory shall also be tested.]

Testing is also indicated for opportunistic infections and certain cancers, as well as for some patients with a positive purified protein derivative (PPD) test, Venereal Disease Research Laboratory (VDRL), or a history of a sexually transmitted disease.

[g.(1) An inmate being considered for full-term release, parole, good conduct time release, furlough, or placement in a community-based program such as a Community Corrections Center (CCC) shall be tested for the HIV antibody. An inmate who has been tested within one year of this consideration ordinarily will not be required to submit to a repeat test prior to the lapse of a one-year period. An inmate who refuses to be tested shall be subject to an incident report for refusing an order and will ordinarily be denied participation in a community activity.

(2) A seropositive test result is not sole grounds for denying participation in a community activity. Test results ordinarily must be available prior to releasing an inmate for a furlough or placement in a community-based program. When an inmate requests an emergency furlough, and current (within one year) HIV and HBV antibody test results are not available, the Warden may consider authorizing an escorted trip for the inmate, at government expense.

h. (1) No later than thirty days prior to release for parole or placement in a community-based program, the Warden shall send a letter to the Chief United States Probation Officer (USPO) in the district where the inmate is being released, advising the USPO of the inmate's positive HIV or HBV status. A copy of this letter shall also be forwarded to the Community Corrections Manager. The Community Corrections Manager, in turn, shall notify the Director of the CCC (if applicable). In all instances of notification, precautions shall be taken to ensure that only authorized persons with a legitimate need to know are allowed access to the information.]

In the case of inmate test results, authorized persons with a legitimate need to know may include medical personnel (to include dental and psychological personnel), post-release personnel and federal law enforcement personnel. See Attachment B for a sample letter to the USPO.

[(2) Prior to an HIV- or HBV-infected inmate's participation in a community activity (including furloughs), notification of the inmate's infectious status shall be made:

(i) By the Warden to the USPO in the district to be visited, and

(ii) By the Health Service Administrator to the state health department in the state to be visited, when that state requires such notification.

Notification is not necessary for an escorted trip.]

Notification of the USPO shall be through a letter initiated by the unit manager for approval by the Warden. For release by parole or to a community based program, the CD shall prepare a diagnostic summary for each HIV-positive patient prior to release. The summary shall include:

- a synopsis of the patient's diagnosis, care, and treatment;
- a description of laboratory and x-ray findings; and
- recommendations for follow-up care.

This summary shall be sent to the USPO no later than 30 days prior to the anticipated date of release. The HSA shall notify the appropriate state health department by letter with notification occurring prior to the inmate's expected arrival.

[(3) Prior to release on parole, completion of sentence, placement in a community-based program, or participation in an unescorted community activity, an HIV-positive or HBV-infected inmate shall be strongly encouraged to notify his/her spouse (legal or common-law) or any identified significant others with whom it could be assumed the inmate might have contact resulting in possible transmission of the virus.]

The HSA shall encourage this notification.

[(4) When an inmate is confirmed positive for HIV or HBV, the HSA shall be responsible for notifying the state health departments in the state in which the institution is located and the state in which the inmate is expected to be released, when either state requires such notification. The HSA shall ensure medical staff perform the notification at the time of confirmed positive HIV or HBV antibody tests.

(5) The HSA shall notify the Immigration and Naturalization Service (INS) of any inmate testing positive who is to be released to an INS detainer.

i. Inmates receiving the HIV or HBV antibody test shall receive pre- and post-test counseling, regardless of the test results.]

Pre- and post-test counseling shall be the institution physician's responsibility; however, any health care provider may conduct the actual counseling. Pre- and post-test counseling should address the limitations of the test, i.e., the inability to detect early infections, false positives, false negatives, and the possible need for additional testing as well as the complications and consequences of a negative or positive test result. An inmate being considered for release/community activities shall be given counseling as provided in the appropriate counseling form.

Medical staff shall counsel an inmate testing positive about the disease process, how to maintain health, and how to avoid transmission to others. Pregnant inmates who test positive shall also be advised as to the likelihood that the virus may be transmitted to the fetus. An inmate testing positive shall be referred to the Psychology Department for follow-up counseling.

Forms BP-490 (61), BP-491 (61), and BP-492 (61), shall be used when counseling is performed. The counselor shall review the appropriate standardized post-test counseling form with the patient. Form BP-489 (61) is to be used to document counseling, and then be included in the patient medical record in section 6. Signature and retention of forms BP-490 (61), BP-491 (61), and BP-492 (61) are at the counselor's discretion.

[j. Health service staff shall clinically evaluate and review each HIV-positive inmate at least once quarterly.]

The prevention and treatment of HIV and HBV infections serve to restrict the spread of the diseases and to maintain the quality of life for those suffering from them. Health service staff shall monitor HIV and HBV positive inmates closely, including attention to tests for determination of immune system status.

[k. Pharmaceuticals approved by the Food and Drug Administration for use in the treatment of AIDS, HIV-infected, and HBV-infected inmates shall be offered, when indicated, at the institution.]

l. If a patient requires hospitalization, the Warden shall submit a request for medical transfer through the Medical Designator.

m. When an inmate is transferred, medical staff shall note in the accompanying BP-149's Special instructions section: "CDC Universal Precautions are to be Observed when Transporting Any Inmate." For HIV or HBV-positive inmates transferred to other jurisdictions, e.g., state or county facilities, the Warden shall send a letter (see Attachment B) to that facility's administrator, in addition to, but separate from the BP-149.

This use of form BP-149 applies to all inmates, not merely HIV- or HBV-infected inmates. This conforms with the CDC guidelines and HIV and HBV educational efforts.

n. Staff may evaluate inmates who are seriously ill as a result of their HIV or HBV infection for re-sentencing consideration pursuant to 18 U.S.C. §§ 4205 (g) or 3582(c), as appropriate. These requests must be handled pursuant to the provisions of the Program Statement on Compassionate Release.

o. Employees who feel they have been exposed to hazardous blood and body fluids while on duty shall report this exposure to their supervisor and the medical department, where a BP-MED-73 report shall be completed. employees shall be informed of the need to complete a CA-1 with the institutional Safety Manager.

If the institution physician determines that possible exposure occurred, HIV as well as HBV testing and pre- and post-test counseling shall be offered to the employee. Retesting shall be offered to the employee if the CD deems it necessary. The institution shall absorb all costs associated with this program. The employee may seek medical care from his/her private physician and may pursue reimbursement for other medical care through Workman's Compensation.

18. TUBERCULOSIS. All institutions shall comply with the recommendations and guidelines as published by the CDC in, Control of Tuberculosis in Correctional Facilities: A Guide for Health Care Workers, U.S. Government Printing Office: 1992-632-867, and the most recent Department of Health and Human Services (DHHS) and CDC Guidelines for Preventing the Transmission of Tuberculosis in Health-Care Facilities, Second Edition.

a. Responsibilities. The HSA and CD shall have supervisory responsibility for the design, implementation, and maintenance of the institutional tuberculosis infection control program. The HSA and CD shall jointly be responsible for all institutional administrative measures of the DHHS guidelines and recommendations, to include developing and implementing effective written policies and protocols for the tuberculosis infection control program.

The HSA and Safety Manager shall have responsibility for developing, implementing, and maintaining all DHHS-recommended institutional engineering/environmental controls for the tuberculosis infection control program.

The Safety Manager shall have the responsibility for implementation, education, and maintenance of all personal protective equipment as recommended by the DHHS for the tuberculosis infection control program.

* b. Testing. The CD shall ensure that tuberculin skin testing (Mantoux method) is provided for all institution employees and inmates. The testing of inmates shall be consistent with Section 10.c.(3) of this Program Statement.

All prospective employees at Bureau institutions shall receive a Mantoux (PPD) skin test (chest x-ray if clinically indicated) as a condition of employment. All employees at Bureau institutions shall be offered a yearly tuberculin skin test or chest x-ray. *

The health care provider evaluating the skin test shall document the results, in millimeters of induration, in the employee's or inmate's medical record. Any employee who demonstrates conversion from negative to positive status by the skin test shall be referred to his/her private health care provider for any further care and appropriate notification made.

The CD shall require documentation from the employee's health care provider of any treatments and recommendations for care or employment. The employee must sign a release of information form allowing the transfer of the information to the CD. The release of information authorization shall be maintained in the employee's medical record. The CD shall provide written recommendations to the Warden regarding duty assignment or employment status consistent with 5 CFR §339.101-339.306. The recommendations are to be consistent with the employee's health status and any potential risks of transmission of tuberculosis or threat to the health and well-being of other inmates or employees.

All positive skin test results shall be reported to the appropriate state health department consistent with state regulations. The medical personnel interpreting the results shall document in the employee's or inmate's medical record any relevant medical history regarding past or recent exposure to tuberculosis, Bacillus of Calmette and Guerin (BCG) vaccination, symptoms suggestive of tuberculosis, and any current health problems connected with tuberculosis, e.g., HIV-infection.

In the case of a PPD positive skin test, the examining medical personnel shall document any known recent exposures to tuberculosis. The CD shall evaluate and counsel all PPD positive employees and inmates.

c. Respiratory Protection for Staff. Because of the close confinement of individuals in correctional institutions, inmates and staff may be susceptible to the disease. It can be transmitted when an infected individual coughs, speaks, sings, or spits.

(1) Special Precautions. Contacts with a person with suspected TB, as identified by a primary health care provider, require special precautions. For non-medical referral centers, arrangements shall be immediately made to transport the inmate to a local hospital with the necessary facilities to isolate the inmate from other patients. OSHA Guidelines require the ability to medically isolate (e.g. negative pressure isolation room) active/suspected TB cases until arrangements for transport to a local hospital can occur. Although a person presenting clinical indications may not have TB, he or she is to be treated as if infected until it is confirmed that the disease is not present or treatment renders the disease non-infective.

(2) Removal from General Population. If an inmate is clinically suspected to have TB as diagnosed by a primary health care worker, he or she is to be removed from the prison general population immediately. If the institution has a negative pressure isolation room, the inmate shall be placed in this room until arrangements can be made to transport and admit him or her to a local hospital with facilities to treat TB. If the

institution does not have a negative pressure isolation room, the inmate is to be placed in a room with outside ventilation and outside exhaust until transportation to the local hospital can be arranged.

(3) Transportation to Local Hospitals. As noted above, at non-medical referral centers, an inmate with suspected TB is to be transported immediately to a local hospital. When transporting the inmate, special care must be taken. Escort personnel must wear a high efficiency particulate air **(HEPA) respirator**. R&D staff out-processing the inmate as well as any other staff member who must come into contact with the inmate, must wear HEPA masks. The inmate is to be moved from the holding area to R&D in a manner to eliminate or absolutely minimize contact with other staff or inmates. The inmate shall be issued and wear a standard "surgical-type" mask. HEPA respirators may adversely affect the breathing of an inmate who is potentially infected with TB and may not be used.

Any inmate with clinically suspected TB is to be transported alone to the local hospital. No other inmates shall be transported on the same trip.

(4) Warning Signs. When occupied by a suspected TB case, an isolation room shall have a warning sign posted outside. The warning shall indicate that special respiratory isolation is necessary and that no one is to enter the room without authorization. The only exception is when it is evident the inmate poses a danger to self and/or others.

(5) Respiratory Protection. Any staff member entering the room of the suspected TB patient shall wear special respiratory protection. OSHA has determined that the respiratory protection to be worn shall consist of a National Institute of Occupational Safety and Health (NIOSH) approved HEPA respirator. HEPA respirators must be fitted to the individual employee. For the respirator to work effectively there must be a tight seal between the face and the skin. Beards, sideburns, and certain hair styles, along with the absence of dentures may interrupt the seal.

To ensure there are sufficient staff to transport and provide escort for an inmate suspected of having TB, each non-medical referral center Warden shall identify 15 correctional officers, three lieutenants, four R&D personnel, and all clinical health services personnel for fittings with HEPA respirators. These individuals shall provide escort and/or treatment for any person suspected of having TB. Wardens at Medical Referral Centers shall determine how many additional staff need to be fit tested with HEPA respirators. Individuals identified must be medically screened for suitability to wear a HEPA respirator. Medical staff at the institution shall perform this screening.

(6) Guard Service at Local Hospitals. Institutions using guard services for hospital escort shall require that they be fit-tested, trained and utilize HEPA respiratory protection. Unless the Warden is reasonably certain that guard service personnel have been trained and fit-tested to use HEPA respirators, escort of inmates with suspected TB cases is to be completed by Bureau personnel.

(7) Medical Referral Centers. Medical Referral Centers with appropriate treatment facilities may isolate and/or treat an offender with suspected or active TB. Inmates from non-medical referral centers are generally not to be transferred to a MRC for isolation or treatment. The Medical Director must approve any exception to this policy.

(8) Appearances at Court, INS, or U.S. Parole Commission Hearings. If for any reason an inmate with clinically suspected TB is scheduled to appear at Court or an INS or U.S. Parole Commission hearing, the Warden shall ensure the appropriate hearing authority is notified the inmate is undergoing treatment for clinically suspected TB and cannot be moved until a determination of infectivity is made. If possible, a tentative treatment timetable and date of inmate availability should given to the hearing authority when the information is being presented.

(9) HEPA Respirator Purchase. Each institution shall purchase disposable HEPA respirators, which will necessitate purchasing a quantity for each designated staff member. They shall be stored in the health services storage area. Used disposable masks are to be disposed of in health services infectious waste containers. Health services staff are responsible for proper disposal of all infectious waste. The cost of the purchase of HEPA respirators and training and fit-testing, as necessary, shall be incurred locally.

(10) Training. The Safety Manager at each institution is to be trained in the necessary functions to provide fit testing for employees. Subsequently, the Safety Manager shall provide each employee fitted with a HEPA respirator the training necessary in its wear and use. The Safety Manager is to provide to the Business Office a list of recommended vendors for purchase. A number of the vendors will, upon request, provide fit-test training to staff, and will, on occasion fit-test employees themselves.

All training for the Safety Manager and or designated employees is to be documented and placed on the staff member's training record.

(11) Reporting. An inmate, who has been identified with clinically suspected TB, is to be reported via EMS to the National Infectious Disease Program Coordinator. The EMS is to include the diagnostic rationale for identifying the person as a suspected case and the steps taken to ensure respiratory isolation. If a suspected case is found to have active TB, this data is to be entered into the Sensitive Medical Data (SMD) component of SENTRY. A positive PPD must not to be entered into SMD as positive TB.

(12) Local Procedures. All of the above noted procedures shall be included into the local Respiratory Protection Program.

19. SEXUALLY TRANSMITTED DISEASES. All sexually transmitted diseases shall be treated in accordance with the CDC Treatment Guidelines, as published in the **Morbidity and Mortality Weekly Report**, volume 38, number S-8, September 1, 1989.

20. OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION STANDARD (OSHA) ON BLOODBORNE PATHOGENS 29 CFR §1910.1030

a. Compliance. All institutions shall comply with the OSHA standard as set forth in 29 CFR §1910.1030.

b. Exposure Control Plan. Each HSA and CD shall develop a written exposure control plan as specified in the standard. At a minimum, the exposure control plan shall include the:

(1) exposure determination,

(2) procedures for evaluating the circumstances surrounding an exposure incident, and

(3) schedule and method for implementing sections of the standard covering the methods of compliance, HIV and HBV research laboratories and production facilities, hepatitis B vaccination and post-exposure follow-up, communication of hazards to employees and inmates, and recordkeeping.

c. Plan Updates. The HSA and CD shall review the plan, update it at least annually or whenever new tasks and procedures affect occupational exposure, make it accessible to employees and inmates (in accordance with 29 CFR § 1910.1030(e), Access to Employee Exposure and Medical Records and make it available to the Assistant Secretary for OSHA and to the Director of the National Institute for Occupational Safety and Health (NIOSH) for examination and copying.

d. Exposure Incident. The HSA and CD shall ensure that all post-exposure medical evaluation and follow-up is available immediately for anyone (staff or inmate) involved in an exposure incident, including the hepatitis B vaccine and vaccination series.

At a minimum, the evaluation shall:

- Document the routes of exposure and how exposure occurred.
- Identify and document the source individual, unless the HSA can establish that such identification is not feasible.

Within 15 days after the evaluation, the HSA shall provide the exposed individual a copy of the health care professional's written opinion, which shall:

- be limited to whether the vaccine is indicated and if it has been received,
- document that the individual has been informed of the results of the evaluation and of any medical conditions resulting from the exposure incident that may require further evaluation or treatment, and
- NOT include any diagnosis.

All diagnoses shall be confidential.

e. Occupational Exposure Determination. The exposure determination shall be based on the definition of occupational exposure without regard to personal protective clothing and equipment. The HSA and CD shall make the exposure determination by reviewing job classifications within the work environment and listing exposures into two groups. The first group includes job classifications in which all of the individuals have occupational exposure, such as operating room scrub nurses. When all employees and inmates have occupational exposure, it is not necessary to list specific work tasks. The second group includes those classifications in which some of the employees and inmates have occupational exposure.

When there are only some employees and inmates who have occupational exposure, specific tasks and procedures causing occupational exposure shall be listed. An example would be in a hospital's laundry where some of the workers might be assigned the task of handling contaminated laundry while others would not. When employees and inmates with occupational exposure have been identified, the next step is to communicate the hazards to these individuals.

f. Communicating Exposure Hazards. Bloodborne Pathogen training shall be provided to all new employees within 10 working days of employment. Information and training shall be provided at no cost to the individual, at the time of initial assignment, during working hours, and at least once a year thereafter. Additional training is required when existing tasks are modified or new tasks that involve occupational exposure to bloodborne pathogens affect the individual's exposure.

Persons conducting training shall be knowledgeable about the subject matter. The information provided shall be appropriate in content and vocabulary to the educational level, literacy, and language of the audience, and shall contain the following elements:

(1) Obtaining a copy of the regulatory text and an explanation of its contents;

(2) Information on the epidemiology and symptoms of bloodborne diseases;

(3) Ways in which bloodborne pathogens are transmitted;

(4) Explanation of the exposure control plan and how to obtain a copy;

(5) Information on recognizing tasks that might result in occupational exposure;

(6) Explanation of the use and limitations of work practice and engineering controls and personal protective equipment;

(7) Information on the types, selection, proper use, location, removal, handling, decontamination, and disposal of personal protective equipment;

(8) Information on hepatitis B vaccination such as safety, benefits, efficacy, methods of administration, and availability;

(9) Information on who to contact and what to do in an emergency;

(10) Information on reporting an exposure incident and on the post-exposure evaluation and follow-up;

(11) Information on warning labels, signs (where applicable), and color-coding; and

(12) Question and answer session on any aspect of the training.

g. Preventive Measures (Hepatitis B Vaccination). The vaccine and vaccinations, as well as all medical evaluations and follow-up, shall be made available at no cost to the individual, provided at a reasonable time and place, and performed by or under a physician's or another health care professional's supervision whose scope of practice allows him or her to independently perform activities required by paragraph (f) of the standard (such as a physician assistant or nurse practitioner). The institution shall incur costs associated with this program.

(1) The CD or health care professional shall review and complete the Vaccine Information form BP-S552(61) for any individual to whom the vaccine is offered.

(2) If vaccine administration is deemed appropriate and the individual consents, the physician or health care professional shall also review and complete the Vaccine Consent form BP-S439(61). Vaccinations shall be administered according to the current U.S. Public Health Service recommendations.

(3) Employees and inmates who decline the vaccination shall sign a declination form BP-S440(61). The employee or inmate may request and obtain the vaccination at a later date and at no cost if he/she continues to be exposed.

(4) The hepatitis B vaccine and vaccination series shall be offered within 10 working days of initial assignment to employees and inmates who have occupational exposure to blood or other potentially infectious materials unless:

- the individual has previously received the complete hepatitis B vaccination series;
- antibody testing reveals that the individual is immune; or
- medical reasons prevent taking the vaccinations.

Pre-screening is not required for employees before receiving the hepatitis B vaccination series. Pre-screening is strongly recommended for inmates prior to receiving the vaccine.

(5) The HSA shall obtain and provide the employee or inmate with a copy of the health care professional's written opinion stating whether a hepatitis B vaccination is indicated for the individual and whether the individual has received such vaccination.

(6) The institution shall provide any booster doses of the hepatitis B vaccine the U.S. Public Health Service recommends.

h. Universal Precautions. Universal precautions shall be observed. This method of infection control requires the employer and individual to assume that all human blood and specified human body fluids are infectious for HIV, HBV, and other bloodborne pathogens. Where differentiation of types of body fluids is difficult or impossible, all body fluids are to be considered as potentially infectious.

i. Methods of Control Engineering and Work Practice Controls. Engineering and work practice controls are the primary methods used to prevent occupational transmission of HBV and HIV. Personal protective clothing and equipment also are necessary when occupational exposure to bloodborne pathogens remains even after instituting these controls.

(1) Engineering Controls. Engineering controls reduce employee exposure in the workplace by either removing or isolating the hazard or isolating the worker from exposure. Self-sheathing needles, puncture-resistant disposal containers for contaminated sharp instruments, resuscitation bags, and ventilation devices are examples of engineering controls. The HSA shall be responsible for examining and maintaining or replacing engineering controls regularly.

(2) Work Practice Controls. Proper work practice controls alter the manner in which a task is performed. In work areas where a reasonable likelihood of occupational exposure exists, work practice controls include restricting eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses; prohibiting mouth pipetting; preventing the storage of food and/or drink in refrigerators or other locations where blood or other potentially infectious materials are kept; providing and requiring the use of handwashing facilities; and routinely checking equipment and decontaminating it prior to servicing and shipping. Other work practice requirements shall include, but are not limited to, the following:

(a) Washing hands when gloves are removed and as soon as possible after skin contact with blood or other potentially infectious materials occurs.

(b) Recapping, removing, or bending needles is prohibited unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure. When recapping, bending, or removing contaminated needles is required by a medical procedure, this shall be done by mechanical means, such as the use of forceps, or a one-handed technique.

(c) Shearing or breaking contaminated needles is not permitted.

(3) Personal Protective Equipment. Personal protective equipment also shall be used if occupational exposure remains after instituting engineering and work practice controls, or if those controls are not feasible.

(a) The use of personal protective equipment helps prevent occupational exposure to infectious materials. Such equipment includes, but is not limited to, gloves, gowns, laboratory coats, face shields or masks, and eye protection. Personal protective equipment is considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach individuals' work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment is used.

(b) Under the standard, the HSA shall provide, make accessible, and require the use of personal protective equipment at no cost to the individual. The HSA shall provide personal protective equipment in appropriate sizes. Hypoallergenic gloves or other similar alternatives shall be made available to individuals who have an allergic sensitivity to gloves. The HSA and CD shall ensure that protective equipment is properly used, cleaned, laundered, repaired or replaced, as needed, or discarded.

(c) An employee may temporarily and briefly decline wearing personal protective equipment under rare and extraordinary circumstances and when, in the employee's professional judgment, it prevents the delivery of health care or public safety services or poses an increased hazard to workers. These circumstances would be expected to be life threatening. In general, appropriate personal protective equipment is expected to be used whenever occupational exposure may occur. This discretionary activity is prohibited for inmates.

(4) Personal Protective Equipment Use. The HSA and CD shall ensure that employees and inmates observe the following precautions for safely handling and using personal protective equipment:

(a) Remove protective equipment before leaving the work area and after a garment becomes contaminated.

(b) Place used protective equipment in appropriately designated areas or containers when being stored, washed, decontaminated, or discarded.

(c) Wear appropriate gloves when it can be reasonably anticipated that the employee may have contact with blood or other potentially infectious materials, when performing vascular access procedures, and when handling or touching contaminated items or surfaces. Replace gloves if torn, punctured, or contaminated or when their ability to function as a barrier is compromised.

(d) Utility gloves may be decontaminated for reuse if their integrity is not compromised. Discard utility gloves when they show signs of cracking, peeling, tearing, puncturing, or deteriorating.

(e) Never wash or decontaminate disposable gloves for reuse.

(f) Wear appropriate face and eye protection such as a mask with glasses with solid side shields or a chin-length face shield when splashes, sprays, spatters, or droplets of blood or other potentially infectious materials pose a hazard to the eye, nose, or mouth.

(g) Wear appropriate protective body coverings such as gowns, aprons, caps, and boots when occupational exposure is anticipated. The type and characteristics will depend upon the task and degree of exposure anticipated.

(5) Housekeeping. Under the standard, each place of employment shall be kept clean and sanitary. The HSA and CD shall ensure that a cleaning schedule has been developed and implemented that includes appropriate methods of decontamination and tasks or procedures to be performed. This written schedule shall be based on the location within the facility, the type of surfaces to be cleaned, the type of contamination present, the tasks or procedures to be performed, and their location within the facility.

The HSA shall ensure that the following housekeeping procedures are followed:

(a) Clean and decontaminate all equipment and environmental work surfaces that have been contaminated with blood or other potentially infectious materials.

(b) Decontaminate work surfaces with an appropriate disinfectant after completion of procedures, immediately when overtly contaminated, after any spill of blood or other potentially infectious materials, and at the end of the work shift when surfaces have become contaminated since the last cleaning.

(c) Remove and replace protective coverings such as plastic wrap and aluminum foil when contaminated.

(d) Inspect and decontaminate regularly reusable receptacles such as bins, pails, and cans that have a likelihood for becoming contaminated. When contamination is visible, clean and decontaminate receptacles immediately or as soon as feasible.

(e) Always use mechanical means such as tongs, forceps, or a brush and a dust pan to pick up contaminated broken glassware; never pick up with hands even if gloves are worn.

(f) Store or process reusable "sharps" in a way that ensures safe handling and prevents accidental injury.

(g) Place other regulated waste in closable and labeled or color-coded containers. When storing, handling, transporting, or shipping, place other regulated waste in containers that are constructed to prevent leakage.

(h) When discarding contaminated "sharps," place them in containers that are closable, puncture-resistant, appropriately labeled or color-coded, and leakproof on the sides and bottom.

(i) Ensure that "sharps" containers are easily accessible to personnel and located as close as is feasible to the immediate area where "sharps" are used or can be reasonably anticipated to be found. "Sharps" containers also shall be kept upright throughout use, replaced routinely, closed when moved, and not allowed to overfill.

(j) Never manually open, empty, or clean reusable contaminated "sharps" disposal containers.

(k) Discard all regulated waste according to Federal, state, and local regulations.

(l) Handle contaminated laundry as little as possible and with a minimum of agitation.

(m) Use appropriate personal protective equipment when handling contaminated laundry.

(n) Place wet contaminated laundry in leak-proof, labeled or color-coded containers before transporting.

(o) Bag contaminated laundry at its location of use.

(p) Never sort or rinse contaminated laundry in areas of its use.

(6) Labeling. Fluorescent orange or orange-red warning labels shall be attached to containers of regulated waste, to refrigerators and freezers containing blood and other potentially infectious materials, and to other containers used to store, transport, or ship blood or other potentially infectious materials (Label shall indicate "Infectious Waste"). These labels are not required when:

(a) red bags or red containers are used,

(b) containers of blood, blood components, or blood products are labeled as to their contents and have been released for transfusion or other clinical use, and

(c) individual containers of blood or other potentially infectious materials are placed in a labeled container during storage, transport, shipment, or disposal.

The warning label shall be fluorescent orange or orange-red, contain the biohazard symbol and the word BIOHAZARD, in a contrasting color, and be attached to each object by string, wire, adhesive, or another method to prevent loss or unintentional removal of the label.

As already indicated, the above preventive measures are intended to eliminate or minimize the risks of occupational exposure. In the event that an exposure occurs, however, certain procedures are required.

(7) Control Responsibilities. The HSA and Safety Manager shall be responsible for examining and maintaining or replacing regularly any engineering controls (see 29 CFR §1910.1030 (d)1-2).

i. Recordkeeping. The HSA shall preserve and maintain for each individual an accurate record of occupational exposure according to OSHA's rule governing access to employee exposure and medical records, 29 CFR, Part 1910.20.

The HSA shall maintain vaccination and exposure information by the VAC-TRAC II data system, furnished by the vendor, SmithKline Beecham. Separate data directories or diskettes shall be maintained for inmates and staff. All data shall be maintained on diskette and secured to ensure confidentiality and prevent loss of data or information. The diskettes shall be maintained in the institution and furnished to the Medical Director upon request.

j. Medical Records. Under the bloodborne pathogens standard, however, medical records also shall include the following information:

(1) Employee's name and social security number; inmate's name and registration number;

(2) Individual's hepatitis B vaccination status including vaccination dates and any medical records related to the individual's ability to receive vaccinations;

(3) Results of examinations, medical testing, and postexposure evaluation and follow-up procedures;

(4) Health care professional's written opinion; and

(5) A copy of the information provided to the health care professional.

Medical records shall be kept confidential and maintained for at least the duration of employment plus 30 years or for the duration of incarceration plus 30 years.

k. Training Records. The HSA shall maintain and keep accurate training records pertaining to OSHA Standards for three years which shall include:

- Training dates,
- Content or a summary of the training,
- Names and qualifications of trainers, and
- Names and job titles of trainees.

Upon request, the HSA shall make available both medical and training records to the Director of the National Institute for Occupational Safety and Health (NIOSH) and to the Assistant Secretary of Labor for Occupational Safety and Health. The HSA shall make available training records to employees or employee representatives upon request. If the individual ceases employment at the facility or if the inmate is transferred or completes his/her sentence, medical and training records shall be transferred to the new employer or institution. If there is no successor employer or institution, the HSA shall notify the Director, NIOSH, DHHS, for specific directions regarding disposition of the records at least three months prior to intended disposal.

21. FINANCIAL MANAGEMENT. Program costs shall be monitored through the National Infectious Disease Program Coordinator.

\s\
Kathleen M. Hawk
Director

CDC HIV CLASSIFICATION SYSTEM

The CDC classifies the manifestations of HIV infection into four categories. The terms AIDS and ARC are not used in the classification scheme, nor does the classification scheme directly relate to the severity of the patient's infection. Hence, it does not provide explicit prognostic information. Classification is hierarchical in that once an individual has been classified in a higher group he or she will not be reclassified in a lower group even if the individual should experience clinical improvement.

Group I. Acute HIV Infection.

Acute infection by the human immunodeficiency virus causes a mononucleosis-like syndrome in many individuals. It may be associated with an aseptic meningitis and will be followed by seroconversion, usually within six to twelve weeks, of initial infection. Outpatients initially categorized in Group I will be reclassified into another following resolution of the acute syndrome.

Group II. Asymptomatic HIV Infection.

Human immunodeficiency virus infection is frequently asymptomatic. The patient may have a positive test for the HIV antibody but have no signs or symptoms of illness.

Group III. Persistent Generalized Lymphadenopathy.

The patient is placed in Group III if he or she has palpable lymphadenopathy at two or more extra-inguinal sites for greater than three months in the absence of a concurrent illness or condition other than HIV infection which might explain the lymphoid swelling. Patients with adenopathy whose clinical condition causes them to be classified in Group IV will not be reclassified in Group III even if the condition leading to classification in Group IV resolves.

Group IV: Opportunistic Infections, Cancers, the Wasting Syndrome, and Other Severe Manifestations of Viral Infection.

The fourth group of patients with HIV infection is divided into a number of subgroups. Assignment is based on the diagnosis of particular opportunistic infections, cancers, neurologic diseases, constitutional diseases or poorly defined disorders associated with severe immune deficiency.

Subgroup A - Constitutional Diseases

Defined as one or more of the following: fever persisting more than one month; involuntary weight loss of greater than 10% of baseline; or diarrhea persisting more than one month; and the absence of a concurrent illness or condition other than HIV infection to explain the findings.

Subgroup B - Neurologic Diseases

Defined as one or more of the following: dementia, myelopathy, or peripheral neuropathy; and the absence of a concurrent illness or condition other than HIV infection to explain the findings.

Subgroup C - Secondary Infectious Diseases

Defined as the diagnosis of an infectious disease associated with HIV infection and/or at least moderately indicative of a defect in cell-mediated immunity. Patients in this subgroup are divided further into two categories.

Category C-1

Includes patients with symptomatic or invasive disease due to one of 12 specified secondary infectious diseases listed in the original CDC surveillance definition of AIDS.

A. Pneumocystis carinii pneumonia
B. Chronic Cryptosporidiosis
C. Toxoplasmosis
D. Extra Intestinal Strongyloidiasis
E. Isosporiasis
F. Candidiasis (Esophageal, Bronchial or Pulmonary)
G. Cryptococcoses
H. Histoplasmosis
I. Mycobacteria infection with Mycobacterium avium complex of M. Kansassi
J. Cytomegalovirus Infection
K. Chronic mucocutaneous or disseminated herpes simplex virus infection
L. Progressive multi-focal leukoencephalopathy

Category C-2

Includes patients with symptomatic or invasive disease due to one of six other specified secondary infectious diseases.

A. Oral Hairy Leukoplakia
B. Multi-dermatomal Herpes Zoster
C. Recurrent Salmonella Bacteremia
D. Nocardiosis
E. Tuberculosis
F. Oral Candidiasis (Thrush)

Subgroup D - Secondary Cancers

Defined as the diagnosis of one or more kinds of cancer known to be associated with HIV infection as listed in the original CDC surveillance definition of AIDS and at lest moderately indicative of a defect in cell-mediated immunity.

A. Kaposi's Sarcoma
B. Non-Hodgkin's Lymphoma (small, noncleaved lymphoma or immunoblastic sarcoma)
C. Primary lymphoma of the brain.

Subgroup E - Other Conditions in HIV Infection

Defined as the presence of other clinical findings or diseases, not classifiable in subgroups A through D, that may be attributed to HIV infection and/or may be indicative of a defect in cell-mediated immunity. Included are patients with chronic lymphoid interstitial pneumonitis. Also included are those patients whose signs or symptoms could be attributed to HIV infection or to another coexisting disease not classified elsewhere, and patients with other clinical illnesses, the course or management of which may be complicated or altered by HIV infection. Individuals also included in this group are those who have CD4 counts of less than 200 cells per mm^3 and display no other symptoms.

(INSTITUTION LETTERHEAD)

(ADDRESSEE)

Re: (INMATE'S NAME)
(REGISTRATION NUMBER)
(DOCKET NUMBER)

Dear (PROBATION OFFICER'S NAME):

This is to inform you that (INMATE'S NAME) will be transferred to (YOUR JURISDICTION/HALFWAY HOUSE), on (DATE).

While (INMATE'S NAME) health is considered good, you should be aware the (HE/SHE) has tested positive for (HUMAN IMMUNODEFICIENCY VIRUS {HIV} and/or HEPATITIS B VIRUS {HBV}). While confined (HE/SHE) has been living and working in the general inmate population without adversity and in compliance with the Centers for Disease Control recommendations.

Because of the strict requirements of medical confidentiality, you should take precautions to ensure that the above information is only released to authorized personnel on a "need to know" basis. (INMATE'S NAME) is aware of the positive test result and has been counseled regarding the medical implications of (HIS/HER)condition.

A limited number of Bureau of Prisons' staff have knowledge of (INMATE'S NAME) test results. Please contact me or the Clinical Director directly if you require additional information.

Sincerely,

Warden

cc: Inmate's Medical File

INFORMATION ON THE VACCINE

The Disease

Hepatitis means inflammation of the liver. Hepatitis B, which is a viral infection, is one of multiple causes of hepatitis. Most people with Hepatitis B recover completely, but approximately 5-50% become chronic carriers; 1-2% die of fulminant hepatitis. In the group of chronic carriers, many have no symptoms and appear well, yet can transmit the virus to others. Others may develop a variety of symptoms and liver problems varying from mild to severe (chronic persistent hepatitis, chronic active hepatitis, cirrhosis and liver failure). There is also an association between Hepatitis B virus and hepatoma (a form of liver cancer).

Hepatitis B virus can be transmitted by contact with body fluids including blood (including contaminated needles), semen, tears, saliva, urine, breast milk, and vaginal secretions. Health workers are at high risk of acquiring Hepatitis B because of frequent contact with blood or potentially contaminated body fluids and, therefore, vaccine is recommended to prevent the illness.

The Vaccine

Hepatitis B Vaccine [Recombinant] is a noninfectious Recombinant DNA Hepatitis B Vaccine. Clinical studies have shown that after three doses 96% of healthy adults have been sero-protected.

Persons with immune system abnormalities, such as dialysis patients, have less response to the vaccine, but over 67% of those receiving it do develop antibodies. If you have immune deficiency problems, you should obtain a written release from your physician.

Dosing Schedules

Three doses of Hepatitis B Vaccine are needed to confer protection. The vaccine is usually administered at 0, 1, and 6 months for routine vaccinations. For post-exposure vaccinations, the vaccine is usually administered at 0, 1, and 2 months.

Adverse Reactions

Hepatitis B Vaccine [Recombinant] is generally well tolerated. During clinical studies involving thousands of individuals distributed over all age groups, no serious adverse reactions attributable to vaccine administration were reported. As with any vaccine, however, it is possible that expanded commercial use of the vaccine could reveal rare adverse reactions not observed in clinical studies. The most frequently reported adverse reactions were injection-site soreness, fatigue, induration,

erythema, swelling, fever, headache, and dizziness. Other more serious adverse reactions have occurred infrequently. If you have any questions about Hepatitis B or about the vaccine, please ask.

Contraindications

Hypersensitivity to yeast or any other component of the vaccine is a contraindication for use of the vaccine.

Warnings

Patients experiencing hypersensitivity after a Hepatitis B Vaccine [Recombinant] injection should not receive further injections *(see Contraindications).*

Hepatitis B has a long incubation period. Hepatitis B Vaccination may not prevent Hepatitis B infection in individuals who have an unrecognized Hepatitis B infection at the time of vaccine administration. Additionally, small percentage of healthy people do not respond to the vaccine and do not develop an immunity to the HBV.

Pregnancy

Pregnancy Category C: Animal reproduction studies have not been conducted with hepatitis B vaccines. It is also not known whether hepatitis B vaccine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. The vaccine should be given to a pregnant woman only if clearly needed.

Nursing Mothers

It is not known whether hepatitis B vaccine is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when the vaccine is administered to a nursing woman.

Approval from Physician

Yes_____ No_____ Approved for Vaccination

_____ _____
Physician's Signature Date

CONSENT FORM

I,_____, have read the above statement about Hepatitis B and the Hepatitis B Vaccine. I have been provided with updated information and have had the opportunity to ask questions about the benefits and risks of Hepatitis B Vaccination. I understand that there is no guarantee that I will become immune and that there is a possibility that I will experience an adverse side effect from the vaccine.

FOR WOMEN

I have been advised that studies have not been conducted to determine the effect of the vaccine on a developing fetus. Therefore, the safety of the vaccine is not known on the developing fetus.

_____ _____
Signature of the Recipient Date

_____ _____
Signature of the Witness Date

APPENDIX A to SECTION 1910.1030
{Hepatitis B Vaccine Declination (MANDATORY)}

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Signature:_____ Date:_____

HIV Counseling Documentation

Directions:

Use the following criteria to counsel the patient who is tested for the HIV antibody. Check off each item as they are discussed. Write NA beside any item that is inappropriate to the situation. Secure this form until pre- and post-test counseling is completed, then file this form in the patient's chart, documenting in progress notes that counseling was completed as provided on forms BP-490(61), BP-491(61), and BP-492(61), as appropriate.

PRE-TEST:

_____ 1. Explain purpose of session.

_____ 2. Explain confidentiality.

_____ 3. Explain HIV antibody test.

____ a. What AIDS is
____ b. What the test is
____ c. Test Procedure
____ d. Meaning of test results
____ e. Inability of detect early infections (false negatives.)
____ f. Possibility of false positives
____ g. Possible need for additional testing
____ h. Complications and consequence of a positive test.

_____ 4. List risk factors.

_____ 5. Explain prevention recommendations for persons with possible exposure.

_____ 6. Obtain informed consent (when applicable).

_____ 7. Risk Reduction Behaviors. Educational material provided.

_____ 8. Patient Reactions/Comments.

Inmate Name:_____ Register No:_____

I understand the above information about the HIV test.

_____ _____
Signature of Inmate Signature of Staff Counselor

Date:_____

HIV Counseling Documentation

POST-TEST: Seronegative

_____ 1. Explain purpose of session.

_____ 2. Review confidentiality.

_____ 3. Test Information

____ a. Inform patient of negative test result.
____ b. Explain purpose of test.
____ c. Identify remaining risks.
____ d. Explain inability of test to detect early infections. (false negatives)

_____ 4. Explain risk reduction behaviors (high risk)

_____ 5. Discussed follow-up testing (high risk)

_____ 6. Give additional education material if requested.

_____ 7. Patients Reactions/Level of Understanding/Comments

I understand the above information.

_____ _____
Signature of Inmate Signature of Staff Counselor

Date:_____

****

Seropositive Post-Test Counseling

_____ 1. Confidentiality review.

_____ 2. Patient informed of results of test by physician.

_____ 3. Patient referred to the psychology department for follow-up counseling.

_____ _____
Signature of Inmate Signature of Staff Counselor

Date:_____

HIV PRE-TEST COUNSELING

You are being tested for evidence of infection by the human immunodeficiency virus (HIV) by the Bureau of Prisons. This virus is associated with development of the disease commonly known as AIDS.

Please circle below the reason for being tested and any risk factors you may have:

REASONS

1. Release
2. Volunteer
3. Clinically indicated
4. Admission program
5. Follow up on HIV Review Program
6. Random Sample

RISK FACTORS

1. Intravenous Drug (sharing needles)
2. Sexual Activity
   a. multiple partners
   b. homosexual activity
   c. partners who are HIV-Positive or IV drug users
3. Blood transfusion
4. Tattooing

Some common questions that are asked concerning testing are listed below:

1) How do I know that the test is perfectly accurate?

The test does have some technical limitations. You need to understand the terms false positive and false negative. False positive is the situation where the test indicates evidence of infection when, in fact, there is not. False negative is the opposite situation where the test indicates no evidence of infection when the individual is infected.

2) Why do these "errors" occur?

These are actually not "errors", but simply represent the technical limitations of the test. The test cannot detect early infection. This happens because the test does not test for the virus itself, but instead measures proteins in the blood that are a reaction of the body to infection by the virus. There is a period of time that is required for these proteins to appear in measurable amounts. Therefore, in this case, one would have a negative test, but actually be infected with the virus. This would be an example of a false negative. false positives can occur due to the fact that the screening test can occasionally detect proteins similar, but not identical to the ones that are present when and individual is infected. This test will read positive, when the individual is not actually infected.

3) How do you find out if you are a false positive?

Your health care provider will inform you of this situation when he reviews your test with you. All tests that are "positive" by the screening test are automatically tested using a second method. This second test is very specific, and tests positive only in people who are actually infected. When the screening test is positive and the specific test is negative, this situation is medically interpreted as a negative result. However, follow up testing is usually done in this case.

4) How long do I have to wait for the results?

In our setting, the results are usually available in about two weeks.

5) How often should I be tested?

This depends on the individual situation. The best advice is to consult your health care provider and obtain their recommendations.

6) Can this test affect me in any way?

This test is no different than any other blood test. It gives a result that will be used in providing future health care. You cannot contract AIDS from having the test done, nor can it be contracted by donating blood or having any other blood test for that matter.

7) Who sees these test results?

The results of these tests are absolutely confidential and are revealed to no one except on a "need to know" basis, such as the warden.

If you have additional questions, be sure to write them down so that they can be discussed with your health care provider when the results of the test are reviewed with you. There will be an additional handout governing test results at that time.

_____	_____	_____
Inmate Name	Register #	Date

(Signature and Retention in Medical Record at Discretion of Counselor)

HIV POST-TEST COUNSELING
(NEGATIVE)

Your recent test for evidence of infection with the human immunodeficiency virus (HIV) has been determined to be negative. This virus has been associated with the disease known as AIDS, and the negative results mean there is no evidence of infection.

Commonly asked questions are listed below:

1) Even though the test is negative, can I still be positive?

As mentioned in the pre-test handout, there are false negatives. This is generally the case when people have recently been infected, due to the fact that it takes some time for the proteins that are measured in test to develop after infection.

2) Does this mean I should be retested?

This question should be answered for your individual situation by your health care-provider. In general, however, if you have not been involved in any high-risk behavior, and this continues to be the case, there is little reason to be concerned with developing a positive test.

3) What is "high-risk" behavior?

These are behaviors that make you more likely to contact infection with the HIV virus. High-risk activities are listed below:

a) Homosexual Activity - Having sexual contact with members of your same sex who are infected.

b) Intravenous Drug Use - Sharing needles with an infected person and then injecting a substance into your body. If the needle has been in another person's body, it can come into contact with the virus which then can be transferred to your body by the needle.

c) Blood Transfusion or Organ Transplants - This is really no longer of much concern since our screening tests are quite good and theoretically we should be able to screen out virtually all people who are infected.

d) Heterosexual Activity - Having sexual contact with members of the opposite sex who are infected.

e) Maternal Infection - Fetuses can contract the disease from an infected mother and be born with an active infection with the virus.

4) Can I still catch the disease?

Certainly, and that is done by engaging in any of the "high-risk" activities.

5) Can I spread the disease?

Since your test is negative, probably not. However, remember that there is a time lapse between infection and the time when your test turns positive. This was discussed under the first question.

6) How long does it take for a person's test to turn positive if he is infected?

The full answer to this question is not yet known. There is evidence that this can take up to several years. However, generally this will occur in about three months after exposure.

7) How can I protect myself from infection?

Simply, by avoiding the "high-risk" behavior list. However, we realize that upon release, people are not going to abstain from sex, and in some cases, from using IV drugs, and people may occasionally have a need for a blood transfusion. We hope the information below will be helpful:

With regard to sexual activity, having sex with only one partner who is not infected is the only way to insure that one does not contract the disease by this method. If you do choose to engage in sexual activity, the best current method of prevention is to use a condom or "rubber" to prevent contact with your partner's body fluids. This is not a perfect solution since condoms sometimes tear.

With regards to intravenous drug use, it is hoped that you could completely abstain from this in the future. If you do choose to engage in this activity, you can reduce your chances of infection by rinsing the "works" with a bleach solution since this kills the virus. You should contact a health care provider knowledgeable in this area to get specific instructions. If you possibly can, always use needles that are sterile.

If you have any future questions, discuss them with your health care provider.

Inmate Name	Register #	Date

(Signature and Retention in Medical Record at Discretion of Counselor)

HIV-POST-TEST COUNSELING (POSITIVE)

Your recent testing for evidence of infection with the human immunodeficiency virus (HIV) has returned, and the results are positive. This indicates that you have been exposed to the virus, and are presumably infected. This virus is associated with the disease as AIDS.

Commonly asked questions are listed below:

1) Does this mean that I will get AIDS?

This is a question that is difficult to answer completely at this time. Some researchers believe that not all infected persons develop that illness. Others believe that all infected people will but that the length of time until they develop AIDS varies. For practical purposes, this will be a lifelong problem for you, and will require ongoing medical care to monitor your individual situation.

2) Can the lab have made a mistake?

It is possible. However, with the current test in use, this is very unlikely. Further testing is generally done, and if the test is repeatedly positive, and other tests are consistent with infection, there is little room for error.

3) Does this mean I have AIDS now?

Not necessarily. The disease known as AIDS is the last stage of infection with the HIV. There are four stages as follows:

Stage 1-This individual has been infected with the virus, but not enough time has elapsed for the blood proteins to develop which turn the tests positive. This was discussed in the pre-test handout under false negative.

Stage 2-Progressing to this stage simply means that the blood test has returned positive. By definition, you are at least a stage 2 patient. Quite often, these individuals feel quite well, and are otherwise normal.

Stage 3-The change that occurs in developing this stage is the presence of swollen glands on the body. These are in the neck and under the armpits, and any of these that you notice should be reported to your physician. You may note some swelling of the glands in the groin and leg area. These are not necessarily related to HIV infection, but if you notice them getting larger, it would be good to mention this to your physician. Again, you will usually feel quite well, but have positive tests for the HIV.

Stage 4 - This stage is the disease known as AIDS. The following is a simplified version of what happens. The HIV lives in a cell called a T-helper cell. They are called this because they "help" the immune system fight off "foreign invaders" like bacteria, viruses, and parasites. The HIV lives in the cell, and by an unknown mechanism, decides to start making more viruses rapidly. When these viruses accumulate the cell falls apart, releasing the viruses into the bloodstream and they then make a new home in another T-helper cell. This process is repeated until most of the T-helper cells have been killed. This leads to a weakening of the immune system, rather like an army that has suffered too many casualties to be strong any more. At this point, the body becomes susceptible to infection with the "foreign invaders" and cannot fight them off. Treatments are available for many of these problems, but these treatments need some help from the immune system. At some point, the person finally succumbs to one of these infections.

Treatments and preventive measures are improving as time progresses, but most are still in the research phase at this time.

4) How did I get this infection?

Infection with this virus occurs during what we refer to as "high-risk" behavior.

5) What is "high-risk" behavior?

These are behaviors that make you more likely to contract infection with the virus. High-risk activities are listed below:

a) Homosexual Activity - Having sexual contact with members of your same sex who are infected.

b) Intravenous Drug Use - Sharing needles with an infected person and injecting a substance into your body. If the needle has been in another person's body, it can come into contact with the virus which then can be transferred to your body by the needle.

c) Blood Transfusion or Organ Transplants - This is really no longer of much concern since our screening tests are quite good and theoretically we should be able to screen out virtually all people who are infected.

d) Heterosexual Activity - Having sexual contact with members of the opposite sex who are infected.

e) Maternal Infection - Fetuses can contact the disease from an infected mother and be born with an active infection with the virus.

6) Can I spread this to other people like my wife and children?

Studies have shown that children of AIDS patients (stage 4) are no more at risk for developing this disease than any one else. Basically, the normal activities of daily home life like kissing your children, using the same eating utensils, etc. are not risk factors for spreading this illness. With respect to your spouse, it is possible to spread the virus through sexual intercourse as mentioned previously. Discuss with your physician what means you may want to use to prevent this spread. The best prevention is, of course, to abstain from sex. This is rather unlikely, so the next best means is to use a condom or "rubber". This is not foolproof because the condoms sometimes tear or leak. Basically, the virus is spread by you to another person if you engage in "high-risk" behavior.

7) What do I do now with respect to medical care?

Your physician will advise you as to what is best in your particular case. Usually, this involves periodically taking further blood tests to check for the number of T-helper cells. This is a good way of identifying person in which the virus is actively reproducing. The physician will advise you of the test results are as they are available, and how often you should have them done. He will also advise you of any treatments that are necessary.

8) Does any one else know these test results, or will they be told?

Your test results are absolutely confidential. No one else is informed, except on a "need to know" basis, such as the unit psychologist.

_____	_____	_____
Inmate Name	Register #	Date

(Signature and Retention in Medical Record at Discretion of Counselor)